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RESEARCH ARTICLE



Risk of Revictimization within Intimate Relationships among Women Survivors of Childhood Sexual Abuse: The Role of Cumulative Trauma and Self-Capacities Disturbances

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ABSTRACT

Childhood sexual abuse, especially in the context of cumulative childhood interpersonal trauma (CCIT), is associated with an increased risk of revictimization by an intimate partner among women. The aim of the present study is to examine the role of self-capacities disturbances in the association between CCIT and revictimization by an intimate partner. The sample comprised of 247 adult women survivors consulting in sex therapy. Path analyses showed an indirect effect of self-capacities disturbances in the association between CCIT and revictimization ($ORs=1.49$ and 1.62), demonstrating the importance of intervening in relational and affective difficulties among women survivors to prevent the risk of revictimization.

Childhood sexual abuse (CSA) is a serious public health issue affecting nearly one in five girls worldwide before the age of 18 (Stoltenborgh et al., 2011). Empirical literature has established CSA as an important risk factor for a variety of long-term difficulties in adulthood (MacIntosh & Ménard, 2021). Notably, CSA has been associated with deleterious impacts on intimate relationships later in life (e.g., lower relationship satisfaction; Godbout et al., 2017; Lassri et al., 2018). One of these key impacts is the increased risk of being revictimized within the context of intimate relationships (Hébert et al., 2021), particularly among women (Brassard et al., 2020). Revictimization within the context of intimate relationships, which refers to victimization by an intimate partner after CSA, occurring either in adolescence or adulthood (Hébert et al., 2012), constitutes an important issue that requires a better understanding of the mechanisms at play to support survivors; this support can aid survivors in identifying their specific strengths and vulnerabilities and reinforce their resilience against further abuse. As such, examining these mechanisms could help identify key factors to address in prevention and treatment efforts focused on women survivors and should not be interpreted as a way of blaming victims for their experiences. In the current study, revictimization within intimate relationships refers specifically to physical and sexual violence sustained by an intimate partner or ex-partner among CSA survivors.

Although most studies focus solely on nonintimate partner sexual revictimization (e.g., see Walker et al., 2019), studies that documented revictimization within the context of an intimate relationship among adult women CSA survivors indicated alarming prevalence rates. For example, a study conducted on 16,993 individuals from the community who were currently in a relationship, or had recently been in a relationship, showed that women CSA survivors were at least two times more at risk of experiencing physical or sexual violence ($OR=2.85$ and 4.78 ,

respectively) within their intimate relationship compared to non-victims (Daigneault et al., 2009). Another study conducted among 1,001 women from the community demonstrated that 40.0% of those who had experienced CSA had also experienced intimate partner physical violence in their lifetime (Brassard et al., 2020). Furthermore, a study conducted on 204 heterosexual newlywed couples from the community showed that women with a history of CSA experienced more acts of sexual violence by an intimate partner in the past year compared to those without a history of CSA (DiLillo et al., 2016). These rates highlight the need to pay particular attention to the elements linking CSA to a risk of revictimization in the context of intimate relationships.

CSA and cumulative interpersonal trauma

Numerous studies have shown that CSA rarely occurs in isolation, demonstrating that the majority (e.g., 74.7%, Hébert et al., 2018) of children who experience CSA also experience other interpersonal trauma. In fact, CSA survivors tend to report cumulative childhood interpersonal trauma (CCIT; Finkelhor et al., 2007, 2009). CCIT refers to the accumulation of two or more different forms of abusive or neglectful experiences that occur during childhood (i.e., before the age of 18), including physical, sexual, and psychological abuse, physical and psychological neglect, exposure to intimate partner violence, and bullying by peers (Rassart et al., 2022). Many explanations were put forward for this phenomenon, such as environmental circumstances (e.g., lack of supervision, isolation) that may increase the risk for a variety of victimization experiences (Finkelhor et al., 2007).

Studies have also revealed that the experience of CCIT represents a significant vulnerability factor of revictimization within adults' intimate relationships (e.g., Brassard et al., 2020). Indeed, Pereda and Gallardo-Pujol (2014)'s study showed that CCIT was significantly linked to the number of revictimization experiences in adulthood. Another study conducted on 60 young mothers showed that a higher rate of CCIT was associated with a steeper increase in the rate of intimate partner physical revictimization during adolescence (Kennedy et al., 2017). However, the literature shows significant gaps. Notably, a large proportion of studies examining revictimization among women CSA survivors have only focused on sexual revictimization experienced outside of an intimate relationship (Classen et al., 2005). Moreover, studies among clinical samples of women consulting help services are scarce, yet these women represent a vulnerable population who are more likely to report having experienced CCIT (Berthelot et al., 2014) and violence within intimate relationships (Hamberger et Larsen, 2015). It appears crucial to examine revictimization within intimate relationships among a clinical sample of women survivors to better understand the potential mechanisms (i.e., processes and associations between variables) involved and to provide empirically-based knowledge that can guide intervention. Moreover, examining mechanisms such as self-capacities disturbances (i.e., affective, identity, and relational disturbances) may offer an interesting avenue for understanding revictimization among survivors.

Self-capacities disturbances as potential explanatory mechanisms of revictimization

A systematic review of recent empirical literature revealed that few studies have addressed the specific mechanisms of revictimization within the context of intimate relationships among women CSA survivors, and those that have done so report heterogeneous or fragmented results (Hébert et al., 2021). Findings have shown that potential psychological repercussions of CCIT, such as posttraumatic stress symptoms (Hébert et al., 2017, 2021), could partially explain revictimization in women survivors. However, the few available studies have neglected to identify explanatory mechanisms that account for the complexity of the repercussions of CCIT among CSA survivors (Hébert et al., 2021).

Briere's Self-Trauma Model (1996, 2002) offers a theoretical framework encompassing the key repercussions of CCIT that could act as risk factors for later revictimization within intimate

relationships. This conceptual model suggests that childhood interpersonal trauma hinders one's optimal development, leading to complex disturbances or deficits in self-capacities (Briere, 2002). Self-capacities are one's personal resources that allow one to cope with distress without resorting to maladaptive coping strategies (Allen, 2011). Self-capacities disturbances include affect, identity, and relational disturbances (Bigras & Godbout, 2020; Briere, 2002; Rassart et al., 2022).

Affective disturbances

Affective disturbances refer to psychological distress and the inability to tolerate and regulate intense, negative emotions without resorting to inappropriate tension-reduction activities or being overwhelmed with internalized difficulties (Briere & Runtz, 2002). Affective disturbances might occur in the aftermath of traumatic experiences in childhood, as trauma exposes the child to events that cause too much distress to be handled. Such trauma can exceed cognitive resources and affect the development of adaptive strategies in the face of adversities, especially if their caregiver was unable to teach the child to regulate their emotions adequately. Studies have shown that childhood interpersonal trauma is associated with higher affective disturbances throughout more depressive symptoms (Li et al., 2020), as yielding this internalized difficulty may be indicative of impaired affect regulation (Girard et al., 2021; Joormann & Gotlib, 2010; Visted et al., 2018). Studies have also denoted associations between childhood interpersonal trauma and the use of maladaptive tension-reducing activities (e.g., externalizing behaviors such as hurting oneself to deal with internal pain; Liu et al., 2018). Dugal et al. (2018, 2021) have shown a significant association between CCIT, affect regulation difficulties (e.g., affect dysregulation), and sustained psychological revictimization within intimate relationships among samples of adults from the community and adults consulting in sex therapy. Dietrich (2007) documented that affect dysregulation was associated with revictimization in a sample of 207 women both from the community and consulting help services survivors of CCIT. The authors proposed that affective disturbances may interfere with the ability to perceive or act in a risky situation (e.g., level of intoxication, emotional shutdown, risky sexual practices), thus putting CCIT survivors in a more vulnerable position to be revictimized (Dietrich, 2007; Messman-Moore et al., 2010). Yet further investigation is needed to examine the role of affective disturbance indicators (e.g., affect dysregulation, depressive symptoms, tension-reduction activities) in the link between CCIT and revictimization by an intimate partner.

Identity disturbances

Identity disturbances refer to an individual's inability to maintain, with awareness and integration, a distinct, defined, and relatively stable identity, through different situations and interactions with others (Bigras et al., 2020; Briere & Runtz, 2002). Identity disturbances are characterized by dissociation and one's susceptibility to others' influence; this also includes a lack of the capacity to critique others' assertions and to consider oneself before following others' directions (Briere, 2000; Briere & Runtz, 2002; Rassart et al., 2022). Dissociative symptoms (i.e., lack of awareness, depersonalization/derealization, dissociative amnesia, dissociative identity; van Dijke et al., 2018) are considered as an indicator of identity disturbances, as individuals with dissociative symptoms tend to present identity confusion and low awareness and integration to their internal world (Chiu et al., 2017). In the context of CCIT, such identity disturbances could arise due to a child's need to focus their attention in a hypervigilant way toward their unpredictable environment to prevent harm; this may restrain them from turning their attention inwards (i.e., their own thoughts, needs, desires), and their use of dissociation may impede identity development (Briere, 2002). A study also showed that CCIT is associated with later identity disturbances among a mixed sample (i.e., clinical and community) of 374 adults (Bigras et al., 2020). A study by Messman-Moore et al. (2005) showed that identity disturbances, including dissociation, acted as an explanatory mechanism for sexual revictimization in women CSA survivors from the community. Additionally, a longitudinal study,

conducted with 80 at-risk women, identified dissociation as a mediator in the relationship between CSA and later revictimization within intimate relationships (Zamir et al., 2018). Another study revealed an association between CSA, dissociative symptoms, and later revictimization within intimate relationships among a sample of 633 adults from the community (Krause-Utz et al., 2021); however, little is known about CCIT survivors. More studies are needed to better examine the role of identity disturbances (i.e., identity impairment, susceptibility to influence, dissociative symptoms) in the link between CCIT and revictimization by an intimate partner.

Relational disturbances

Relational or relationality disturbances refer to the internalization of negative models of oneself and others within a relational context, with the inability to form and maintain stable and generally harmonious—low conflict—relationships with others (Briere & Runtz, 2002; Rassart et al., 2022). Childhood interpersonal trauma survivors are typically deprived of healthy relationships during their development, thus lacking the opportunity to learn how to form and maintain adequate functioning interpersonal relationships, resulting in later chaotic or conflictual relationships (Bigras et al., 2017; Briere, 2002; Rassart et al., 2022). Furthermore, childhood interpersonal trauma often occurs at the hands of significant attachment figures (e.g., parents or caregivers). As per Bowlby's (1969) attachment theory, one's experiences with their primary caregivers form their internal working models (i.e., understanding of self and others in interpersonal contexts) that guide their expectations of relationships throughout life, including romantic attachment. As such, attachment insecurity (i.e., attachment anxiety and avoidance) is an indicator of relational disturbances that might be a mechanism in the link between CCIT and revictimization. Supporting this postulate, a study conducted on 257 women and 45 men from the community showed that CSA survivors reported more interpersonal conflicts and attachment anxiety than non-victims (Bigras et al., 2015). Additionally, a longitudinal study showed a significant link between childhood interpersonal trauma, attachment insecurity, and revictimization within intimate relationships among a clinical sample of 93 women (Smith & Stover, 2016). Similarly, Dietrich (2007) demonstrated that the poor ability to form meaningful and healthy relationships (e.g., more interpersonal conflicts) acted as a risk factor for revictimization among a mixed sample of 207 CCIT survivors. Authors suggest that survivors may be more likely to accept their partner's violent behaviors for fear of losing the relationship (i.e., attachment anxiety), which can increase the risk of revictimization (Dietrich, 2007; Smith & Stover, 2016). Yet again, further studies are needed to examine the role of relational disturbances (e.g., interpersonal conflicts, attachment anxiety, attachment avoidance) in the link between CCIT and revictimization by an intimate partner.

Despite empirical and theoretical literature supporting self-capacities disturbances as potential mechanisms linking CCIT and later revictimization within intimate relationships, no study has examined them specifically in a single integrative model among a clinical sample of women CSA survivors consulting in sex therapy.

Aim of the study

The present study aimed to examine self-capacities disturbances as mechanisms explaining the link between CCIT and the risk of physical and sexual revictimization within intimate relationships among women CSA survivors consulting in sex therapy. It was expected that CCIT would be positively associated with more self-capacities disturbances (i.e., higher levels of affective, relational, and identity disturbances), which, in turn, would be associated with higher risks of physical and sexual revictimization within intimate relationships. Thus, it is expected that self-capacities disturbances will partly explain the associations between CCIT and the risk of revictimization within intimate relationships.

It needs to be remembered that studying the correlates of revictimization does not aim to hold women survivors accountable for a heightened risk of victimization. Rather, the examination

of the mechanisms that underlie revictimization could help identify key vulnerability factors that could be addressed in prevention and treatment efforts toward women CSA survivors who consult help services as they represent a vulnerable population that is directly affected by intervention programs and recommendations.

Method

Procedure & sample

For this study, trainees and professionals in clinical sexology recruited participants as part of a larger study (i.e., from December 2012 to February 2023). Recruitment targeted individuals or couples consulting help services for sexual or relational difficulties (i.e., sex therapy). Participants were informed about the research project during the first meeting. Patients were informed that their refusal to participate in the study would not affect the access or quality of their care. Interested patients completed the consent form, and then were invited to complete self-report questionnaires alone, without consulting their partner if they had one, on paper or online on a secure platform (i.e., *Qualtrics*). Confidentiality was protected by the attribution of an alpha-numerical code for each participant. The questionnaires were available in French and English. The survey took about 45 minutes to complete.

The following inclusion criteria were applied for the present study: (1) being at least 18 years old, (2) having sufficient knowledge of either French or English, (3), identifying as a woman, (4) reporting an experience of CSA, and (5) having completed at least 80% of the measures of interest. Of the 1,340 patients who provided consent to participate in the large study, 18.4% ($n=247$) met all the inclusion criteria. This research was approved by the institutional review board of the Université du Québec à Montréal.

The final sample was comprised of 247 self-identified adult women who reported having experienced CSA. The mean age of participants was 35.22 years ($SD=12.12$, range = 18–67). Most participants were Canadian (87.0%, $n=215$), French speakers (87.3%, $n=213$), and full- or part-time workers (55.5%, $n=137$). In our sample, most participants completed college or professional studies or lower degrees (55.4%, $n=137$) and had a lower-class personal annual income (i.e., CAD \$40,000; 66.4%, $n=164$). A vast majority of participants were survivors of cumulative interpersonal trauma (93.1%, $n=230$). The sociodemographic and abuse characteristics of the sample are presented in [Table 1](#).

Measures

A sociodemographic questionnaire was used to gather information on participants' age, country of origin (i.e., birthplace), first language, occupation, level of education, and individual annual income.

Childhood sexual abuse

CSA was measured using a gate question based on the criteria of the Canadian Criminal Code (1985) as used in previous studies (e.g., Bigras et al., 2017, Dugal et al., 2021; Rassart et al., 2022). Participants were asked whether they experienced any unwanted sexual contact or any sexual contact with an adult, or someone 5 years older, or someone in a position of authority before the age of 18. Additional optional questions assessed the type(s) of CSA (i.e., verbal solicitation, exposed genitals, exposure to sexual scenes, fondling, oral sex, vaginal or anal penetration, gang rape), the relation with the perpetrator(s) (e.g., father, babysitter, uncle/aunt, neighbor), and the frequency and duration of the experience(s). Participants were classified as having experienced CSA if the answer to any question indicated sexual abuse with or without physical contact before the age of 18. A dichotomous code (0 = absence of CSA, 1 = presence of CSA) was used to classify participants into two groups within our sample.

Table 1. Sociodemographic characteristics.

Characteristics	<i>n</i>	Participants (%)
Birthplace		
Canada	215	87.0
Europe	17	6.9
Central or South America	6	2.4
Asia	4	1.6
Caribbean	3	1.2
Africa	2	0.8
First language		
French	213	86.2
English	8	3.2
Spanish	11	4.5
Other (e.g., Creole, German, Arab)	12	4.9
Occupation		
Student	48	19.4
Full- or part-time worker	137	55.5
Retired	13	5.3
Currently unemployed	17	6.8
Other (e.g., stay at home, invalid)	16	6.5
Education		
Elementary school	6	2.4
High school	39	15.8
College/professional	92	37.2
Undergraduate	85	34.4
Graduate	25	10.1
Individual annual income		
CAD\$19,999 or less	84	34.0
CAD\$20,000 – CAD\$39,999	80	32.4
CAD\$40,000 – CAD\$59,999	40	16.2
CAD\$60,000 or more	38	15.4
Presence of at least one other form of interpersonal trauma		
No	17	6.9
Yes	230	93.1
Cooccurrence of other interpersonal trauma by type		
Physical abuse	122	49.4
Psychological abuse	170	68.8
Physical neglect	62	25.1
Psychological neglect	199	80.6
Exposure to physical partner violence	66	26.7
Exposure to psychological partner violence	157	63.6
Bullying	162	65.6

Cumulative childhood interpersonal trauma

CCIT was assessed using a total score (0–7) based on the presence or absence of a history of seven forms of childhood victimization experience: physical abuse, psychological abuse, physical neglect, psychological neglect, exposure to physical domestic violence, exposure to psychological domestic violence, and bullying. Cumulative interpersonal trauma was assessed using the Childhood Cumulative Trauma Questionnaire (CCTQ; Godbout et al., 2017). In total, participants reported on the 17 items how often they experienced each form in a typical year before the age of 18; this reporting was done on a 7-point Likert scale ranging from “never” (0) to “every day” (6). Each form of trauma was included in the total index score if they had occurred at least once in a typical year before the age of 18. Each form of childhood trauma was first dichotomized as experienced (1), or not (0) and then summed to form a total score ranging from 0—no other childhood interpersonal trauma than sexual abuse to 7—seven different childhood interpersonal traumas in addition to sexual abuse. This composite score is often used in scientific literature on interpersonal trauma (e.g., Bigras et al., 2015; Dugal et al., 2021; Rassart et al., 2022) and reflects past findings that using a cumulative score of childhood interpersonal trauma best predicts the severity of its sequelae (Finkelhor et al., 2007). In this sample, Cronbach’s alpha indicated high internal consistency ($\alpha = .90$; $n = 239$) for the total of 17 items, corresponding to previous alphas from studies using the CCTQ (e.g., Rassart et al., 2022).

Self-capacities disturbances

The three self-capacities disturbances (i. e., affective, relational, and identity disturbances) were assessed with a combination of instruments for each indicator. This method, which allows the examination of a complex combination of multiple symptoms, has been used previously in the scientific literature (Bigras et al., 2017).

Affective disturbances. Affective disturbances included depressive symptoms, affect dysregulation, and tension reduction activities. Each were coded as 0 when below the clinical cutoff, and 1 when above the clinical cutoff, based on the norms of each measure, yielding a total score ranging from 0 (no affective disturbances) to 3 (all indicators of affective disturbances reached clinical significance).

Depressive symptoms. The 13-item Beck Depression Inventory (BDI; Beck et al., 1961; French validation: Bourque & Beaudette, 1982) was used to assess depressive symptoms. Participants reported on how they had been feeling in the last week on a Likert-type scale ranging from 0 to 3. An example of an item was “I do not feel sad” (0), “I feel blue or sad” (1), “I am blue or sad all the time and I can’t snap out of it” (2), and “I am so sad or unhappy that I can’t stand it” (3). Scores range from 0 to 39, and scores higher than 16 indicate severe depression (i.e., clinical cutoff). Cronbach’s alpha indicated high internal consistency in the current sample, ($\alpha = .89$; $n=236$).

Affect dysregulation. Affect dysregulation was assessed with the Inventory of Altered Self-Capacities (IASC; Briere, 2000; French validation: Bigras & Godbout, 2020). This 9-item subscale evaluated the capacity to calm down and to control one’s emotional state on a 5-point Likert scale ranging from “never” (1) to “very often” (5). Total scores ranged from 9 to 45 and were then transformed into a T-score up to 100. T-scores above 70 reflect a clinically significant level of affect dysregulation (i.e., clinical cutoff). Cronbach’s alpha indicated an adequate internal consistency in the present sample ($\alpha = .92$; $n=243$).

Tension-reduction activities. Tension-reduction activities were assessed with the Inventory of Altered Self-Capacities (IASC; Briere, 2000; French validation: Bigras & Godbout, 2020). This 9-item subscale evaluated the tendency to respond to painful internal states with externalizing behaviors such as hurting oneself or using sex and was scored on a 5-point Likert scale ranging from “never” (1) to “very often” (5). Total scores ranged from 9 to 45 and were then transformed into a T-score up to 100. T-scores above 70 reflect a clinically significant level of tension-reduction activities (i.e., clinical cutoff). Cronbach’s alpha indicated an adequate internal consistency in the present sample ($\alpha = .69$; $n=247$).

Relational disturbances. Relational disturbances included attachment anxiety, attachment avoidance and interpersonal conflicts. Each were coded 0 when below the clinical cutoff, and 1 when above the clinical cutoff based on the norms of each measure, yielding a total score ranging from 0 (no relational disturbances) to 3 (all indicators of relational disturbances reached clinical significance).

Adult attachment. Adult attachment was assessed with the Experience in Close Relationships Scale (ECR-12; Brennan et al., 1998; French validation: Lafontaine et al., 2015) This instrument measured two dimensions of attachment insecurity, attachment anxiety and attachment avoidance, on a 7-point scale ranging from 1 (disagree strongly) to 7 (agree strongly) on items such as “I need a lot of reassurance that I am loved by my partner” and “I don’t feel comfortable opening up to romantic partners.” Mean scores were computed, ranging from 1 to 7. Mean scores higher than 3.5 on attachment anxiety and higher than 2.5 on intimacy avoidance reflect a clinically significant level of attachment insecurity (i.e., clinical cutoff; Brassard et al., 2012). In the current sample, Cronbach’s alphas indicated adequate internal consistency for both the attachment avoidance subscale ($\alpha = .87$; $n=245$) and the attachment anxiety subscale ($\alpha = .86$; $n=246$).

Interpersonal conflicts. Interpersonal conflicts were assessed with the Inventory of Altered Self-Capacities conflict scale (IASC; Briere, 2000; French validation: Bigras & Godbout, 2020). This 9-item subscale evaluated the tendency for participants to have problems or arguments in their relationships with others and was scored on a 5-point Likert scale ranging from “never” (1) to “very often” (5). Total scores ranged from 9 to 45 and were then transformed into a

T-score up to 100. T-scores above 70 reflect a clinically significant level of interpersonal conflicts (i.e., clinical cutoff). Cronbach's alpha indicated an adequate internal consistency in the present sample ($\alpha = .90$; $n=229$).

Identity disturbances. Identity disturbances included dissociative symptoms, identity impairment, and susceptibility to influence. Each category was coded 0 when below the clinical cutoff, and 1 when above the clinical cutoff based on the norms of each measure yielding a total score ranging from 0 (no affective disturbances) to 3 (all indicators of identity disturbances reached clinical significance).

Dissociative symptoms. Dissociative symptoms were assessed with the Dissociation scale of the Trauma Symptom Inventory-2 (TSI-2; Briere, 2011; French validation: Godbout et al., 2012). This 10-item scale was used to assess dissociative symptoms (i.e., a facet linked to one's reduced self-concept) on items evaluating alterations to consciousness, perception, memory or identity in the past six months on a 4-point Likert scale ranging from "never" (0) to "often" (3). Total scores ranged from 0 to 30 and were transformed into a T-score of up to 100. T-scores above 65 reflect clinically significant dissociation levels (i.e., clinical cutoff; Briere, 2011). In the current sample, Cronbach's alpha indicated an adequate internal consistency ($\alpha = .84$; $n=244$).

Identity impairment. Identity impairment was assessed with the Inventory of Altered Self-Capacities (IASC; Briere, 2000; French validation: Bigras & Godbout, 2020). The 9-item subscale evaluated the difficulty of maintaining a coherent sense of identity and self-awareness on a 5-point Likert scale ranging from "never" (1) to "very often" (5). Total scores ranged from 9 to 45 and were then transformed into a T-score up to 100. T-scores above 70 reflect a clinically significant level of identity impairment (i.e., clinical cutoff). Cronbach's alpha indicated an adequate internal consistency in the present sample ($\alpha = .89$; $n=228$).

Susceptibility to influence. Susceptibility to the influence of others was measured with the Inventory of Altered Self-Capacities (IASC; Briere, 2000; French validation: Bigras & Godbout, 2020). The 9-item subscale evaluated the tendency to follow others uncritically or without consideration and was scored on a 5-point Likert scale ranging from "never" (1) to "very often" (5). Total scores ranged from 9 to 45 and were then transformed into a T-score up to 100. T-scores above 70 reflect a clinically significant level of susceptibility to influence (i.e., clinical cutoff). Cronbach's alpha indicated an adequate internal consistency in the present sample ($\alpha = .88$; $n=225$).

Revictimization within intimate relationships

Sustained physical and sexual intimate partner violence was assessed using the short-form of the Revised Conflict Tactics Scale (CTS-2; Straus et al., 1996; French validation: Hébert & Parent, 2000). The 6-item physical violence subscale measured the frequency at which the intimate partner hit, kicked, slapped, threw something, or threatened the participants with a weapon over the last year. The 3-item sexual violence subscale measured the frequency at which the intimate partner used insistency, threats, or physical force to have sex with the participant once they had refused over the last year. Both subscales were scored on a 7-point Likert scale ranging from "this never happened" (0) to "more than 20 times during the past 12 months" (6). For this study, a dichotomous code (0=absence of revictimization, 1=presence of revictimization) was created for each subscale, as participants who reported having experienced at least one event of intimate partner sexual or physical violence in the past year were classified as being revictimized, as per the authors' recommendations (Straus et al., 1996). Participants who reported "not in the past year, but it did happen before" (7) were also classified as being revictimized (1).

Statistical analyses

Descriptive and correlation analyses were conducted using SPSS 28 to examine the distribution of the sample and the associations between all study variables. Variables were dichotomized at

their standardized clinical cutoffs, then summed by variable group (i.e., affective-, relational-, or identity-related) based on a statistical and theoretical basis. This method, based on Bigras et al. (2017), overcomes the disproportionate number of individuals with comorbid and overlapping difficulties in a clinical sample (Rutter, 1997), while providing the identification of individuals who are particularly at risk because they possess several vulnerability factors (Farrington & Loeber, 2000; Iselin et al., 2013).

To test the hypothesized integrative model of indirect effects, path analyses were tested using *Mplus*, version 8.4 (Muthén & Muthén, 1998–2017). This software accounted for missing data with Full Information Maximum Likelihood (FIML) and Monte Carlo Integration, which uses randomly generated integration points. The Maximum Likelihood (MLR) estimator, using robust to non-normality and non-independence of observations, was used to obtain odds ratios (ORs; i.e., logistic regression with logit function), and the Maximum Likelihood (ML) estimator was used to accomplish bootstrapping analyses using *Mplus* (Muthén & Muthén, 1998–2017). Examination of the indirect effects of affective, relational, and identity disturbances (i.e., the product of the path coefficients from 1) cumulative interpersonal trauma to each self-capacity deficit, being affective, relational, and identity disturbances, and 2) from each self-capacity deficit to revictimization within intimate relationships) was performed using the *Mplus* model indirect command (Muthén & Muthén, 1998–2017). This bias-corrected method, based on the distribution of the product of coefficients, generates confidence intervals for the true value of coefficients for indirect effects (MacKinnon et al., 2004). A bootstrap confidence interval of 95% on 10,000 samples was used to verify the significance of indirect effects: confidence intervals that do not include zero indicate a significant indirect effect (MacKinnon et al., 2007; MacKinnon & Fairchild, 2009).

Results

Descriptive statistics and correlations

The main results of descriptive statistics (i.e., mean value, standard deviation) and Pearson bivariate correlations are summarized in Table 2. Additional descriptive results are presented in the current sections.

Cumulative childhood interpersonal trauma

Participants reported an average of 3.18 ($SD=1.81$, range 0–7) in terms of different forms of childhood interpersonal trauma; 3.2% ($n=8$) reported having experienced the seven different forms of interpersonal trauma measured in the current study (i.e., physical and psychological abuse, physical and psychological neglect, witness of physical and psychological intimate partner violence, and peer bullying) in addition to CSA.

Self-capacities disturbances

In the present sample, 17.8% ($n=44$) of participants reported a clinical level of depressive symptoms, 54.3% ($n=134$) reported a clinical level of affect dysregulation, and 36.0% ($n=89$) reported a clinical level of tension-reduction activities. In total, 12.1% ($n=30$) of participants reached the clinical threshold on each of the three indicators of affective disturbances. As for relational disturbances, 51.8% ($n=128$) of participants reported a clinical level of intimacy avoidance, 70.4% ($n=174$) of participants reported a clinical level of attachment anxiety, and 40.9% ($n=101$) of participants reported a clinical level of interpersonal conflicts. In total, 18.6% ($n=46$) of participants reached the clinical threshold on each of the three indicators of relational disturbances. As for identity disturbances, 23.5% ($n=58$) of participants reported a clinical level of dissociative symptoms, 48.6% ($n=120$) of participants reported a clinical level of identity impairment, and 36.0% ($n=89$) of participants reported a clinical level of susceptibility to influence. In total, 13.0% ($n=32$) of participants reached the clinical threshold on each of the three indicators of identity disturbances.

Revictimization within intimate relationships

Among participants, 21.9% ($n=54$) reported having experienced physical intimate partner revictimization and 18.2% ($n=45$) reported sexual intimate partner revictimization, indicating that approximately one in five women survivors of CSA had experienced revictimization within intimate relationships in our sample. Among those who reported revictimization, 7.7% ($n=19$) reported having experienced both physical and sexual intimate partner revictimization.

Correlations

Pearson bivariate correlations are presented in Table 2. Statistically significant positive correlations were found between all variables as hypothesized. There were no statistically significant correlations between age, level of education, individual annual income, and both physical and sexual intimate partner revictimization.

Integrative path analysis model

First, the direct paths from cumulative interpersonal trauma to physical revictimization within intimate relationships, $\beta = .20$, $SE = .09$, 95% CI [.04, .37], $p = .022$, and to sexual revictimization within intimate relationships, $\beta = .19$, $SE = .09$, 95% CI [.01, .37], $p = .042$, were found to be significant and indicated positive associations. Cumulative interpersonal trauma among women CSA survivors increased the odds of the presence of physical revictimization within intimate relationships by 23%, $OR=1.23$, 95% CI [1.03, 1.47], and increased the odds of the presence of sexual revictimization within intimate relationships by 22%, $OR=1.22$, 95% CI [1.01, 1.47].

Second, when the intermediate variables were added to the model, the direct paths between cumulative interpersonal trauma and physical revictimization, $\beta = .14$, $SE = .09$, 95% CI [-.03, .32], $p = .117$, and sexual revictimization, $\beta = .16$, $SE = .09$, 95% CI [-.02, .35], $p = .084$, became nonsignificant. The initial integrative model was first tested with no constraints and with all paths being tested (i.e., saturated model). As per Garson's (2014) recommendations, non-significant paths were dropped one at a time and any changes in estimates, coefficients, and model selection criteria (i.e., AIC and BIC metrics) were meticulously noted. For all tested pathways, standardized direct, specific indirect, total indirect, and total effects were estimated (see Table 3 for the data on the removed non-significant paths).

As shown in Figure 1, the associations between cumulative interpersonal trauma and all intermediary variables (i.e., affective, relational, and identity disturbances) were statistically significant. More precisely, path analyses showed that cumulative interpersonal trauma was statistically associated with affective disturbances, $\beta = .28$, $SE = .06$, 95% CI [.17, .40], $p < .001$, relational disturbances, $\beta = .20$, $SE = .06$, 95% CI [.09, .31], $p < .001$, and identity disturbances, $\beta = .13$, $SE = .06$, 95% CI [.00, .26], $p = .044$. In turn, affective disturbances were associated with increased intimate partner physical revictimization, $\beta = .22$, $SE = .08$, 95% CI [.07, .38], $p = .006$. Affective disturbances increased the odds of the presence of physical revictimization within intimate relationships by 48.8%, $OR=1.49$, 95% CI [1.12, 1.98]. Similarly, relational disturbances were statistically associated with intimate partner sexual revictimization, $\beta = .24$,

Table 2. Means, standard deviations, prevalence, and correlation coefficients.

Variable	1	2	3	4	5	6	<i>M</i>	<i>SD</i>	Prevalence (%)
1. Cumulative interpersonal trauma (0-7)	—	.28***	.20**	.13*	—	—	3.18	1.81	—
2. Affective disturbances (0-3)	—	—	.54***	.55***	—	—	1.08	1.05	—
3. Relational disturbances (0-3)	—	—	—	.46***	—	—	1.63	.93	—
4. Identity disturbances (0-3)	—	—	—	—	—	—	1.08	1.07	—
5. Sexual IPV revictimization (0-1)	—	—	—	—	—	—	—	—	21.9
6. Physical IPV revictimization (0-1)	—	—	—	—	—	—	—	—	18.2

Note. IPV=intimate partner violence. * $p < .05$; ** $p < .01$; *** $p < .001$.

Table 3. Removed non-significant paths from the final integrative model.

Removed paths in order	β	SE	95% CI	p	Or	95% CI
1. CCIT → Physical IPV revictimization	.14	.09	-.03, .32	.117	1.16	.96, 1.40
2. CCIT → Sexual IPV revictimization	.16	.09	-.02, .35	.084	1.19	.98, 1.45
3. Affective disturbances → Sexual IPV revictimization	-.03	.12	-.26, .21	.832	.96	.57, 1.34
4. Identity disturbances → Sexual IPV revictimization	.11	.09	-.07, .29	.228	1.21	.90, 1.81
5. Identity disturbances → Physical IPV revictimization	-.13	.11	-.34, .08	.217	.79	.54, 1.17
6. Relational disturbances → Physical IPV revictimization	.06	.10	-.14, .27	.537	1.14	.77, 1.81

Note. CCIT=childhood cumulative interpersonal trauma; IPV=intimate partner violence.

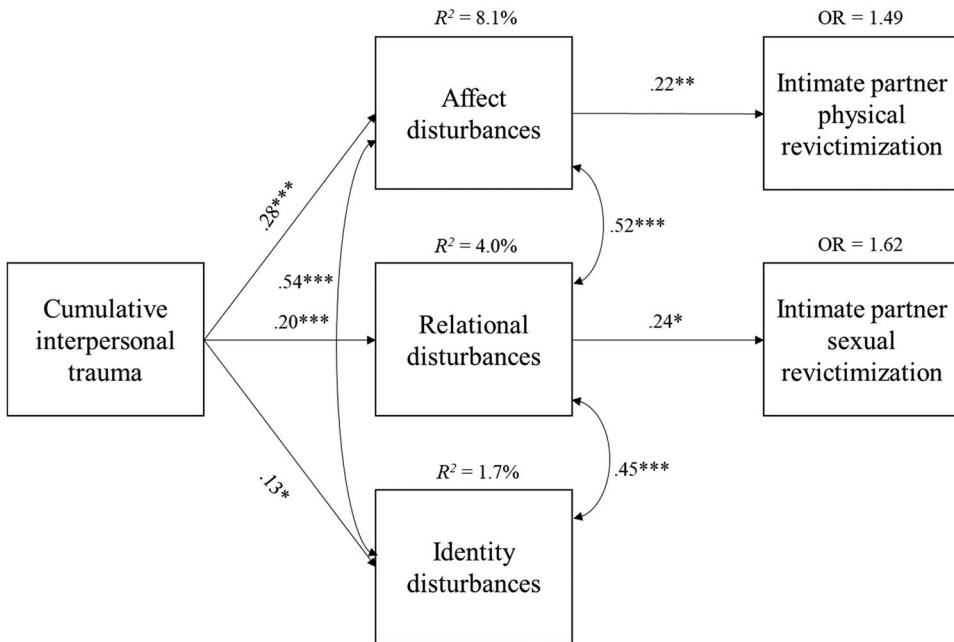


Figure 1. Integrative model of the indirect role of affective, relational, and identity disturbances in the association between childhood cumulative interpersonal trauma and revictimization within intimate relationships among women childhood sexual abuse survivors.

Note. * $p < .05$; ** $p < .01$; *** $p < .001$

SE = .10, 95% CI [.05, .43], $p = .019$, increasing the odds of the presence of sexual revictimization within intimate relationships by 62.4%, $OR=1.62$, 95% CI [1.08, 2.28]. Identity disturbances were not significantly associated with physical, $\beta = -.13$, SE = .11, 95% CI [-.34, .08], $p = .217$, or sexual, $\beta = -.11$, SE = .09, 95% CI [-.07, .29], $p = .228$, revictimization within intimate relationships. Therefore, these paths were removed from the final model. Covariances were statistically significant between affective and relational disturbances, $\beta = .52$, SE = .04, 95% CI [.43, .60], $p < .001$, affective and identity disturbances, $\beta = .54$, SE = .05, 95% CI [.45, .63], $p < .001$, and relational and identity disturbances, $\beta = .45$, SE = .05, 95% CI [.36, .54], $p < .001$.

Finally, the results of path analyses showed two significant indirect associations between cumulative interpersonal trauma and revictimization within intimate relationships. The first indirect association between cumulative interpersonal trauma and physical revictimization was through affective disturbances, $\beta = .06$, SE = .03, 95% CI [.01, .12], $p = .020$, with significant bootstrap confidence intervals, $B = .06$, 95% CI [.02, .13], $p = .023$. The second indirect

association between cumulative interpersonal trauma and sexual revictimization was through relational disturbances, $\beta = .05$, $SE = .02$, 95% CI [.00, .10], $p = .040$, with significant bootstrap confidence intervals, $B = .05$, 95% CI [.01, .11], $p = .047$.

To assess the generalizability of the mediational model across participants, age, level of education, and individual annual income were added as covariates in the model. Results from these additional analyses revealed that controlling for these demographic variables did not change the significance and strength of the associations between the study variables and were not significantly associated with physical or sexual revictimization within intimate relationships.

Discussion

The current study aimed to explore whether the association between CCIT and physical and sexual revictimization within intimate relationships can be explained by clinical levels of self-capacities disturbances among women CSA survivors consulting help services. We hypothesized that more CCIT would be associated with more self-capacities disturbances (i.e., more affective, relational, and identity disturbances), which would, in turn, be associated with an elevated risk of sexual and physical revictimization experience in the context of intimate relationships.

Our results yielded that almost one in four participants (21.9%) reported sexual revictimization, and almost one in five (18.2%) reported physical revictimization by an intimate partner. Although previous studies showed highly heterogeneous prevalence rates of revictimization within intimate relationships among CSA survivors, our revictimization prevalence is lower than the average prevalence found in Walker et al. (2019) meta-analysis of around one in two (47.7%) CSA survivors having had at least one experience of sexual revictimization in their lifetime. This discrepancy could be explained by the specific type of revictimization measured in the present study, i.e., revictimization by an intimate partner and not all types of revictimization (e.g., sexual assault by a nonintimate person, physical revictimization by an intimate partner, etc.). Previous studies generally examined sexual revictimization without specifying the perpetrator (e.g., friend, neighbor, unknown person; Messman-Moore et al., 2005, 2010). Other studies have only examined physical revictimization by an intimate partner and failed to examine sexual revictimization by an intimate partner (e.g., Brassard et al., 2020; Kennedy et al., 2017).

The results of our integrative path analysis model indicated that two self-capacities disturbances, i.e., affective and relational disturbances, acted as mechanisms partially explaining the association between CCIT and later revictimization by an intimate partner. These findings suggest that women CSA survivors who experienced more forms of childhood interpersonal trauma (e.g., psychological abuse, physical neglect) tend to report higher levels of affective disturbances (i.e., more affect dysregulation, greater tendency to use maladaptive tension-reducing activities, clinical-level of depressive symptoms), which in turn puts them in a more vulnerable position to experience physical revictimization by an intimate partner. As such, survivors may experience more psychological distress and difficulties in regulating themselves when feeling negative or intense emotions. Thus, they may come to rely on more impulsive or dysfunctional behaviors to soothe or decrease and/or anesthetize intolerable negative feelings, like self-mutilation, substance abuse or risky sexual behaviors; this could increase their vulnerability or trigger dysfunctional violent reactions from their partner. Additionally, studies have shown that individuals tend to pair with others with similar tendencies, which may increase the likelihood of becoming involved with partners who also experience high levels of affect dysregulation and who may use violence (Dugal et al., 2021). Furthermore, survivors with clinical levels of depressive symptoms may lose hope in diffusing conflicts. They may feel hopeless toward a future without violence, which could enable a sense of powerlessness in the face of one's partner's violence. As depressive symptoms may be reflected by feelings of worthlessness and guilt, depressed survivors may feel as though they deserve their victimization. Intense negative emotions like sadness may also prevent survivors from detecting their partner's danger signals hindering their abilities to protect themselves and prevent further victimization

experiences (Girard et al., 2023). Even if detecting danger signals should not be the victims' responsibility, the ability to be alert and to remove oneself from a risky situation seems to be paramount in empowering women against violence.

Moreover, results have shown that women CSA survivors who experienced more types of childhood interpersonal trauma reported higher relational disturbances (e.g., not getting along with people, worrying about being abandoned, not opening up to other people), which in turn was linked to more risk of sexual revictimization by an intimate partner. As such, survivors with high attachment anxiety may, for example, never refuse their partner's advances out of fear that they will leave them if they refuse. Survivors who have frequent interpersonal conflicts with others may perceive "explosive" couple conflicts as a progression of their usual tumultuous relationships. Additionally, survivors with high intimacy avoidance may be in an intimate relationship with a partner who acts aggressively against them to obtain attention or intimacy, leading to demand-withdrawal patterns.

Although CCIT was related to identity disturbances, these self-capacity disturbances were not linked to the risk of revictimization by an intimate partner in our sample. However, strong positive associations were found between all three self-capacities disturbances, suggesting that identity disturbances are related to relational and affective disturbances and should be targeted to promote improved self-capacities. It is possible that affective and relational disturbances are more proximal to the risk of revictimization, but that identity disturbances among survivors can play a role in maintaining other disturbances.

Empirical and practical implications

The present study adds to the scientific corpus by providing data from a clinical sample of women consulting help services on their physical and sexual revictimization within their intimate relationships and by providing data on the links between CCIT and one's self-capacities.

Our findings may echo the notion of complex posttraumatic stress disorder (CPTSD). The diagnosis of complex posttraumatic stress disorder (CPTSD) proposed by the ICD-11 in 2018 (World Health Organization, 2022) indicates that chronic interpersonal traumas sustained during one's development may lead to disturbances in self-organization: affect regulation problems, negative self-concept (i.e., identity), and relational difficulties (Cloitre et al., 2018, 2019; Cyr et al., 2021). Similarly, the current study highlights the impacts of CCIT on affect regulation, identity development, and interpersonal relationships, which may in turn act as vulnerability factors to revictimization by an intimate partner. As such, intervention practices designed to treat CPTSD can serve as a guide in treating CCIT survivors with self-capacities disturbances and in preventing revictimization. For example, the 3-phase approach to treatment model for complex trauma offers steps to help patients process and resolve their past trauma, to better understand themselves, and to develop meaningful relationships with others (Courtois & Ford, 2013). Phase 1 (Safety, Stabilization, and Engagement) aims to promote safety by identifying survivors' strengths, providing resources, and enhancing emotion identification and regulation. Phase 2 (Trauma Memory and Emotion Processing) aims to help survivors face and process past trauma and its impacts on their emotions, beliefs, and cognitions, using psychoeducation and exposure. By providing a more coherent narrative of survivors' history, this phase promotes better self-understanding and self-compassion, as well as a higher capacity for self-determination and assertiveness by recognizing one's needs and limits. Phase 3 (Consolidating Therapeutic Gains and Application to the Present and Future) aims to apply the knowledge and skills gained throughout the treatment to survivors' daily life and the future challenges. This sequenced treatment model offers a pragmatic guidance in the treatment of CCIT targeting self-capacities disturbances.

Findings of the current study provide a conceptual model to guide intervention programs for CSA survivors or adults who report sexual and/or physical violence by an intimate partner. Results highlight the need to assess CSA along with the history of other interpersonal trauma in women who seek help. Our study showed the complex range of symptoms that can hinder trauma recovery

and place survivors at risk of revictimization in their intimate relationships. Findings suggest that self-capacities disturbances, specifically affective and relational disturbances, could be key mechanisms involved in revictimization in the aftermath of CCIT. As such, practitioners should target the regulation of emotions and the reduction of depressive symptoms, as well as the capacity to develop and maintain stable and mostly harmonious relationships with others, without fear of abandonment or intimacy avoidance, using trauma-sensitive approaches. For example, Trauma-Sensitive Mindfulness-based interventions could help reduce relational disturbances (e.g., fewer difficulties in sustaining relationships and in feeling close to other people; Dumarkaite et al., 2021) and affect regulation (e.g., fewer maladaptive emotion regulation strategies; Gallegos et al., 2015). In fact, Dumarkaite et al. (2021) suggest that Trauma-Sensitive Mindfulness-based interventions may help reduce post-traumatic symptoms, as well as disturbances in self-organization symptoms of complex posttraumatic stress disorder, by increasing self-regulation capacity, which could positively impact self-concept (i.e., identity) and quality of interpersonal relationships. The authors propose that decreasing psychological arousal, increasing attentional control, and fostering acceptance of adverse feelings may help achieve these results (Dumarkaite et al., 2021).

Limitations and further studies

The results of this study should be appreciated in light of its limitations. First, the use of retrospective self-report measures is subject to recall biases and social desirability bias. Yet, retrospective self-reported measures have been found to be reliable in documenting victimization experiences (Newbury et al., 2018) and the fact that participants completed the questionnaires anonymously could temper these biases for all study variables. In addition, the measures used in the present study were dichotomized, making it difficult to provide a detailed picture of symptomatology. Second, the design of this study is correlational and conclusions on the direction of causality or temporal order of the associations between the variables are theory-driven. Studies with longitudinal design are needed to confirm the results. Third, although the present study considered experiences of intimate partner violence beyond the last year as revictimization (i.e., reported “not in the past year, but it did happen before”), only participants who were currently in a relationship completed the questionnaire, and further studies could use more comprehensive measures of revictimization. For example, psychological violence by an intimate partner, which is the most prevalent form of intimate partner violence (Dugal et al., 2018, 2021), may have its own mechanisms that should be explored. Additionally, the current sample was drawn from a large database, which could lead to a selection bias for this study. Finally, participants in our sample were predominantly white, Canadian-born, and employed, which is representative of our population; they also self-identified as heterosexual (75.7%; $n=187$) which is above the average of our population of patients consulting in sex therapy. Further research should nevertheless replicate this study with diverse samples, analyzing potential specificities regarding LGBTQ+ participants and cisgender men. Notably, violence perpetrated against sexual and gender minority women (e.g., lesbian and bisexual women) is a distinct phenomenon that deserves its own empirical study, as they are significantly more likely to report any victimization, including more sustained intimate partner violence (Chen et al., 2020), and specific risk factors may be involved for this population.

Conclusion

In conclusion, this study supports that the repercussions of CCIT on self-capacities may increase women survivors' vulnerability to revictimization by an intimate partner. Findings offer an integrative conceptual model to better understand the underlying mechanisms involved in the aftermath of childhood trauma and revictimization in adulthood. As self-capacities can be improvable, practices and intervention programs aimed at women CSA survivors could promote women's safety in their intimate relationships by promoting healthy affect regulation strategies and enhancing their relational skills while fostering secure attachment to reduce their revictimization risk.

This study aimed to highlight that women should never be blamed for their own victimization, nor should we increase the burden of protecting women from possible revictimization. Rather, it is hoped that acknowledging CCIT and its long-term consequences on women's emotional and relational well-being might help guide well-tailored services that could contribute to the promotion of recovery and prevent subsequent victimization. The ultimate target of this research is to empower women in the prevention of violence perpetrated against them. By empowerment, we mean giving survivors the knowledge and tools that can guide them in their own healing journey and the fight against violence, as this study provides empirical data on violence perpetrated against women inside their own homes.

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Data availability statement

The participants of this study did not give written consent for their data to be shared publicly, so due to the sensitive nature of the research supporting data is not available.

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